WISCONSIN HOSPITAL ASSOCIATION

ADVOCATE. ADVANCE. LEAD.

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Pam Thomas
Regional Administrator
Chicago - Local Engagement and Administration
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 1300
Chicago, IL 60601

Dear Administrator Thomas:

Thank you for your invitation on October 22 to provide input on which of the Public Health Emergency (PHE) flexibilities CMS should consider retaining.

The Wisconsin Hospital Association (WHA) and our member hospitals and health systems again thank CMS for its proactive adoption of multiple waivers to help hospitals meet the unprecedented care demands as a result of the COVID-19 pandemic. These waivers have provided efficiencies and flexibilities that continue to help hospitals and other health care providers to increase care capacity. Many of these waivers address regulatory burdens previously identified by WHA and our member hospitals and health systems prior to the COVID-19 pandemic as unnecessarily limiting the efficient delivery of quality health care, and we are pleased provide input to CMS on such waivers that should be made permanent.

Key feedback on the highest priorities from Wisconsin hospitals and health systems on making current CMS waivers established during the COVID-19 public health emergency permanent have focused on the following:

- **Telehealth.** Permanently retain waivers that remove barriers to telehealth. The removal of outdated CMS regulatory barriers to telehealth has been critical to providing high-quality, efficient. patient-centric access to care during the COVID-19 pandemic. The utilization of telehealth throughout the pandemic has demonstrated the benefits and utility of telehealth options and we urge CMS to make the removal of pre-COVID limitations on telehealth permanent. Permanently removing geographic and location-based restrictions as well as audio-only restrictions are particularly high priorities for our members.

- **Flexibility to manage acute care and post-acute care resources.** Permanently retaining waivers that facilitate "Hospital at Home" models, required 3-day prior hospitalizations and certain post-acute discharge flexibilities. Hospitals' response to the pandemic has demonstrated the impacts that discharge bottlenecks can create on acute care capacity. We urge CMS to permanently retain hospital at home, the required 3-day prior hospitalization for coverage, and certain other post acute discharge flexibilities so that inpatient hospital infrastructure is efficiently used for patients needing inpatient services. We also ask CMS to modify and then retain swing bed flexibilities for PPS hospitals for those situations when a patient needs post-acute care, but a suitable nursing home placement cannot be located.

- **"Top of license" workforce practice.** Permanently retain waivers that enable advanced practice clinicians and other health care professions to practice at the maximum of their state licensed scope of practice. Workforce is a critical, ongoing need for hospitals and health systems; permanently removing outdated CMS regulatory barriers to licensed non-physician practitioner practice in hospitals is critical to fully utilizing our available health care workforce.

- **Critical access hospital flexibility.** Permanently retain waivers impacting critical access hospital (CAH) length of stay and capacity. The waiver of strict limits on CAH beds and length of stay have been important flexibility that has enabled rural hospitals to flexibility address their communities' needs. We encourage CMS to permanently waive the 96 hour length of stay limitations on CAHs, and, post-PHE, create additional flexibility for

CAHs to exceed 25 beds as community needs arise that result in abnormally high acute care demand.

- **Patients over paperwork.** Permanently retain waivers that create additional paperwork or signatures that provide little value or impact on care quality. Ongoing workforce challenges will continue to impact the ability of hospitals and health systems to meet demands for care. We ask for CMS to retain several waivers identified by CMS in its "patients over paperwork" initiative that result in providers spending additional time on compliance and paperwork at the expense of direct patient care. Further, in the face of new and ongoing workforce challenges, removing such barriers becomes even more critical to help stem burnout and further loss among the current workforce.

As requested, we have highlighted below specific current waivers that we encourage CMS to consider permanently retaining. The waivers below and their headers are pulled from the CMS document "Rural Crosswalk: CMS Flexibilities to Fight COVID-19" published in May 21, 2021. Although the audience for the document was for rural audiences, the waivers compiled in this well-organized document equally apply to non-rural facilities as well.

Telehealth and Other Virtual Services

Flexibility	D	RHC	FQHC	CAH	Hospita	SNF
Beneficiary Location for Telehealth Services	Medicare can pay for many types of office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence. Additionally, the HHS OIG is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.[2]	Yes	Yes	Yes	Yes	No
Additional Telehealth Services Covered by Medicare	Clinicians are allowed to provide more than 135 new telehealth services, including: emergency department visits, initial and subsequent observation, initial hospital care and hospital discharge day management, initial nursing facility visits, critical care services, intensive care services, therapy services.[3] On October 14, 2020, using a new expedited process, CMS added 11 new services to the Medicare telehealth services list. Medicare will begin paying eligible practitioners who furnish these newly added telehealth services effective immediately and for the duration of the PHE. These new telehealth services include certain neurostimulator analysis and programming services, and cardiac and pulmonary rehabilitation services.	Yes	Yes	Yes	Yes	Yes

Virtual Check-Ins, Remote Evaluations, & E-Visits	Clinicians can provide virtual check-in, remote evaluation of patient-submitted video/images, and e-visit services to both new and established patients. These services were previously limited to established patients. Licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can provide e-visits, virtual check-ins, and remote evaluations. A broad range of clinicians, including physicians, can now provide certain services by telephone to their patients.	Yes	Yes	Yes	Yes	No
Remote Patient Monitoring	Clinicians can provide remote patient monitoring services to both new and established patients. These services can be provided for both acute and chronic conditions and can now be provided for patients with only one disease.[4]	Yes	Yes	Yes	Yes	No
Removal of Frequency Limitations on Medicare Telehealth	The following services no longer have limitations on the number of times they can be provided by Medicare telehealth: • A subsequent inpatient visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days; • A subsequent SNF visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 30 days; • Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation.	No	No	Yes	Yes	Yes
Eligible Practitioners	CMS is waiving the requirements of section 1834(m)(4)(E) of the Social Security Act and 42 CFR § 410.78 (b)(2) which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. The waiver of these requirements expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.	Yes	Yes	Yes	Yes	Yes

Allowing FQHCs and RHCs to Serve as Distant Sites for Telehealth	FQHCs and RHCs may serve as distant site practitioners to furnish telehealth services. Medicare pays for these telehealth services based on payment rates similar to the national average payment rates for comparable telehealth services under the Medicare Physician Fee Schedule. These services are excluded from both the FQHC prospective payment system and the RHC all-inclusive rate calculation.	Yes	Yes	No	No	No
Physician Visits in SNFs/ Nursing Facilities	CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.	No	No	No	No	Yes
Audio-Only Telehealth for Certain Services	CMS is waiving the requirements of section 1834(m)(1) of the Social Security Act and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services.	Yes	Yes	Yes	Yes	Yes
Non-Physician Practitioner Billing	During the COVID-19 PHE, non-physician practitioners who are eligible to bill Medicare directly, including registered dietitians and nutrition professionals, may bill for audio-only telephone assessment and management services: CPT codes 98966- 98968 (Dates of service on or after March 1 until the end of the PHE).	Yes	Yes	Yes	Yes	No

Hospital Outpatient Fees Accompanying Professional Services Furnished Via Telehealth	When a physician or non-physician practitioner who typically furnishes professional services in the hospital outpatient department furnishes telehealth services during the COVID-19 PHE, they bill with a hospital outpatient place of service since that is likely where the services would have been furnished if not for the COVID-19 PHE. The physician or practitioner is paid for the service under the PFS at the facility rate, which does not include payment for resources such as clinical staff, supplies, or office overhead since those things are usually supplied by the hospital outpatient department. During the COVID-19 PHE, if the beneficiary's home or temporary expansion site is considered to be a provider-based department of the hospital, and the beneficiary is registered as an outpatient of the hospital for purposes of receiving telehealth services billed by the physician or practitioner, the hospital may bill under the PFS for the originating site facility fee associated with the telehealth service.	No	No	Yes	Yes	No
Telemedicine	CMS is waiving the provisions related to telemedicine for hospitals and CAHs at 42 CFR 482.12(a)(8)-(9) and 42 CFR 485.616(c), making it easier for telemedicine services to be furnished to the hospital's patients through an agreement with an off- site hospital. This allows for increased access to necessary care for hospital and CAH patients, including access to specialty care.	No	No	Yes	Yes	No
Hospital-Only Remote Outpatient Therapy and Education Services	Hospitals may bill for services furnished remotely by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is at home when the home is serving as a temporary provider based department of the hospital. Examples of such services include counseling and educational services as well as therapy services.	No	No	Yes	Yes	No
Hospital Only Clinical Staff In-Person Services	Hospital clinical staff must furnish certain services such as infusions and wound care in person given the nature of the services. Under interim final regulations and Hospitals without Walls: • the beneficiary's home can be considered a provider-based department of the hospital for purposes of receiving outpatient services and the beneficiary would be registered as a hospital outpatient. the hospital may bill for these services as hospital outpatient services, provided the PBD is an on campus or excepted off-campus PBD that relocated to the patient's home consistent with the extraordinary circumstances relocation exception policy.	No	No	Yes	Yes	No

CMS Hospital Without Walls

Flexibility	D	RHC	FQHC	CAH	Hospita	SNF
CAH Length of Stay	CMS is waiving the Medicare requirements that CAHs limit the number of beds to 25, and that the length of stay be limited to 96 hours under the Medicare conditions of participation regarding number of beds and length of stay at 42 CFR §485.620.	No	No	Yes	No	No
Telemedicine	CMS is waiving the provisions related to telemedicine for hospitals and CAHs at 42 CFR 482.12(a)(8)-(9) and 42 CFR 485.616(c), making it easier for telemedicine services to be furnished to the hospital's patients through an agreement with an off- site hospital. This allows for increased access to necessary care for hospital and CAH patients, including access to specialty care.	No	No	Yes	Yes	No
Hospital-Only Remote Outpatient Therapy and Education Services	Hospitals may bill for services furnished remotely by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is at home when the home is serving as a temporary provider based department of the hospital. Examples of such services include counseling and educational services as well as therapy services.	No	No	Yes	Yes	No
Hospital Only Clinical Staff In-Person Services	Hospital clinical staff must furnish certain services such as infusions and wound care in person given the nature of the services. Under interim final regulations and Hospitals without Walls: • the beneficiary's home can be considered a provider-based department of the hospital for purposes of receiving outpatient services and the beneficiary would be registered as a hospital outpatient. • the hospital may bill for these services as hospital outpatient services, provided the PBD is an on campus or excepted off-campus PBD that relocated to the patient's home consistent with the extraordinary circumstances relocation exception policy.	No	No	Yes	Yes	No

Expanded Ability for Hospitals to Offer Long-term Care Services ("Swing-Beds")	Under section 1135(b)(1) of the Act, CMS is waiving the requirements at 42 CFR 482.58, "Special Requirements for hospital providers of long-term care services ("swing-beds")" subsections (a)(1)-(4) "Eligibility", to allow hospitals to establish SNF swing beds payable under the SNF prospective payment system (PPS) to provide additional options for hospitals with patients who no longer require acute care but are unable to find placement in a SNF. This waiver applies to all Medicare enrolled hospitals, except psychiatric and long term care hospitals that need to provide post- hospital SNF level swing-bed services for nonacute care patients in hospitals, so long as the waiver is not inconsistent with the state's emergency preparedness or pandemic plan. The hospital shall not bill for SNF PPS payment using swing beds when patients require acute level care or continued acute care at any time while this waiver is in effect. This waiver is permissible for swing bed admissions during the COVID-19 PHE with an understanding that the hospital must have a plan to discharge swing bed patients as soon as practicable, when a SNF bed becomes available, or when the PHE ends, whichever is earlier.	No	No	No	Yes	No
Acute Hospital Care at Home	CMS is executing an innovative Acute Hospital Care At Home program, providing eligible hospitals with unprecedented regulatory flexibilities to treat eligible patients in their homes.[6] This program was developed to support models of at-home hospital care throughout the country that have seen prior success in several leading hospital institutions and networks, and reported in academic journals, including a major study funded by a Healthcare Innovation Award from the Center for Medicare and Medicaid Innovation. The program clearly differentiates the delivery of acute hospital care at home from more traditional home health services. While home health care provides important skilled nursing and other skilled care services, Acute Hospital Care at Home is for beneficiaries who require acute inpatient admission to a hospital and who require at least daily rounding by a physician and a medical team monitoring their care needs on an ongoing basis. To support these efforts, CMS has launched an online portal to streamline the waiver request process and allow hospitals and healthcare systems to submit the necessary information to ensure they meet the program's criteria to participate.[7] CMS will also closely monitor the program to safeguard beneficiaries by requiring hospitals to report quality and safety data to CMS on a frequency that is based on their prior experience with the Hospital At Home model.	No	No	Yes	No	Yes

Patients Over Paperwork

Flexibility	D	RHC	FQHC	CAH	Hospita	SNF
Verbal Orders	CMS is waiving the requirements of 42 CFR §482.23, §482.24 and §485.635(d)(3) to allow for additional flexibilities related to verbal orders where read-back verification is still required but authentication may occur later than 48 hours.	No	No	Yes	Yes	No
Limit Discharge Planning for Hospital and CAHs	CMS is waiving detailed regulatory requirements to provide information regarding discharge planning, as outlined in 42 CFR §482.43(a)(8), §482.61(e), and 485.642(a)(8). The hospital, psychiatric hospital, and CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, home health agency (HHA), SNF, inpatient rehabilitation facility (IRF), and long term care hospital (LTCH) data on quality measures and data on resource use measures. The hospital must ensure that the post acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. During this PHE, a hospital may not be able to assist patients in using quality measures and data to select a nursing home or home health agency, but must still work with families to ensure that the patient discharge is to a post-acute care provide that is able to meet the patient's care needs. CMS is maintaining the discharge planning requirements that ensure a patient is discharged to an appropriate setting with the necessary medical information and goals of care as described in 42 CFR §482.43(a)(1)-(7) and (b).	No	No	Yes	Yes	No
Modify Discharge Planning for Hospitals	CMS is waiving certain requirements related to hospital discharge planning for post- acute care services at 42 CFR §482.43(c), so as to expedite the safe discharge and movement of patients among care settings, and to be responsive to fluid situations in various areas of the country. CMS is waiving certain requirements for those patients discharged home and referred for HHA services, or for those patients transferred to a SNF for post-hospital extended care services, or transferred to an IRF or LTCH for specialized hospital services. CMS is maintaining the discharge planning requirements that ensure a patient is discharged to an appropriate setting with the necessary medical information and goals of care as described in 42 CFR §482.43(a)(1)-(7) and (b).	No	No	No	Yes	No

Medical Records	CMS is waiving 42 CFR §482.24(a) through (c), which cover the subjects of the organization and staffing of the medical records department, requirements for the form and content of the medical record, and record retention requirements. CMS is waiving requirements under 42 CFR §482.24(c)(4)(viii) and §485.638(a)(4)(iii) related to medical records to allow flexibility in completion of medical records within 30 days following discharge and for CAHs that all medical records must be promptly completed.	No	No	Yes	Yes	No
Flexibility in Patient Self Determination Act Requirements (Advance Directives)	CMS is waiving the requirements at section 1902(a)(58) and 1902(w)(1)(A) for Medicaid, 1852(i) (for Medicare Advantage), and 1866(f) and 42 CFR 489.102 for Medicare, which require hospitals and CAHs to provide information about its advance directive policies to patients.	No	No	Yes	Yes	No
Utilization Review	CMS is waiving these requirements at 42 CFR §482.1(a)(3) and 42 C.F.R §482.30, that requires that hospitals participating in Medicare and Medicaid to have a utilization review plan that meets specified requirements. CMS is waiving the entire Utilization Review CoP at §482.30, which requires that a hospital must have a utilization review (UR) plan with a UR committee that provides for review of services furnished to Medicare and Medicaid beneficiaries to evaluate the medical necessity of the admission, duration of stay, and services provided. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/ emergency plan.	No	No	No	Yes	No
Quality Assurance and Performance Improvement Program (Hospitals)	CMS is waiving 482.21(a)-(d) and (f), and 485.641(a), (b), and (d), which provide details on the scope of the program, the incorporation, and setting priorities for the program's performance improvement activities, and integrated QAPI programs (for hospitals that are a part of a hospital system). These flexibilities, which apply to both hospitals and CAHs, should be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan. While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data driven quality assessment and performance improvement program will remain.	No	No	Yes	Yes	No

Nursing Services	CMS is waiving the provision at 42 CFR 482.23(b)(4), 42 CFR 482.23(b)(7), and 485.635(d)(4), which requires the nursing staff to develop and keep current a nursing care plan for each patient, and the provision that requires the hospital to have policies and procedures in place establishing which outpatient departments are not required under to have a registered nurse present. In addition, we expect that hospitals will need relief for the provision of inpatient services and as a result, the requirement to establish nursing-related policies and procedures for outpatient departments is likely unnecessary. These flexibilities apply to both hospitals and CAHs, and should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan.	No	No	Yes	Yes	No
Food and Dietetic Service	CMS is waiving the requirement at 42 CFR 482.28(b)(3) to have a current therapeutic diet manual approved by the dietitian and medical staff readily available to all medical, nursing, and food service personnel. Such manuals would not need to be maintained at surge capacity sites. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan.	No	No	No	Yes	No
3-day Prior Hospitalization for Coverage of a SNF Stay	This waiver of the requirement for a 3-day prior hospitalization for coverage of a SNF stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of disaster or emergency. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period.	No	No	No	No	Yes

"Stark Law" Waivers	The physician self-referral law (also known as the "Stark Law") prohibits a physician from making referrals for certain healthcare services payable by Medicare if the physician (or an immediate family member) has a financial relationship with the entity performing the service. There are statutory and regulatory exceptions, but in short, a physician cannot refer a patient to any entity with which he or she has a financial relationship. On March 30, 2020, CMS issued blanket waivers of certain provisions of the Stark Law regulations. These blanket waivers apply to financial relationships and referrals that are related to the COVID-19 emergency. The remuneration and referrals described in the blanket waivers must be solely related to COVID-19 Purposes, as defined in the blanket waiver document. Under the waivers, CMS will permit certain referrals and the submission of related claims that would otherwise violate the Stark Law.[9]	Yes	Yes	Yes	Yes	Yes
Provider Enrollment	CMS has established toll-free hotlines for all providers as well as the following flexibilities for provider enrollment: • Waive certain screening requirements. • Postpone all revalidation actions. • Expedite any pending or new applications from providers.	Yes	Yes	Yes	Yes	Yes
Relief in Quality Reporting Programs	CMS is granting exceptions from reporting requirements and extensions for clinicians and providers participating in Medicare quality reporting programs with respect to upcoming measure reporting and data submission for those programs.	No	No	Yes	Yes	Yes
Signature Requirements	CMS is not enforcing signature and proof of delivery requirements for Part B drugs and Durable Medical Equipment when a signature cannot be obtained because of the inability to collect signatures. Suppliers should document in the medical record the appropriate date of delivery and that a signature was not able to be obtained because of COVID-19.[10]	No	No	Yes	Yes	No
Respiratory Care Services	CMS is waiving the requirement at 42 CFR 482.57(b)(1) that hospitals designate in writing the personnel qualified to perform specific respiratory care procedures and the amount of supervision required for personnel to carry out specific procedures. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan.	No	No	No	Yes	No

Workforce

Physician Services	CMS is waiving 482.12(c), which requires that Medicare patients be under the care of a physician. This allows hospitals to use other practitioners, such as physician's assistant and nurse practitioners to the fullest extent possible. This waiver should be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.	No	No	No	Yes	No
Anesthesia Services	CMS is waiving requirements under 42 CFR §482.52(a)(5), §485.639(c) (2), and §416.42 (b)(2) that a certified registered nurse anesthetist (CRNA) is under the supervision of a physician in paragraphs §482.52(a)(5) and §485.639(c)(2). CRNA supervision will be at the discretion of the hospital and state law. This waiver applies to hospitals, CAHs, and Ambulatory Surgical Centers (ASCs). These waivers will allow CRNAs to function to the fullest extent of their licensure, and may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.	No	No	Yes	Yes	No
Respiratory Care Services	CMS is waiving the requirement at 42 CFR 482.57(b)(1) that hospitals designate in writing the personnel qualified to perform specific respiratory care procedures and the amount of supervision required for personnel to carry out specific procedures. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan.	No	No	No	Yes	No
CAH Minimum Personnel Qualifications	CMS is waiving the minimum personnel qualifications for clinical nurse specialist, nurse practitioners, and physician assistants described at 42 CFR 485.604 (a)(2), 42 CFR 485.604 (b)(1-3), and 42 C.F.R 485.604 (c)(1-3). Clinical Nurse Specialists, Nurse Practitioners, and Physician Assistants will still have to meet state requirements for licensure and scope of practice, but not additional Federal requirements that may exceed State requirements. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan.	No	No	Yes	No	No

CAH Staff Licensure Deferral	CMS is deferring to staff licensure, certification, or registration to State law by waiving the requirement at 42 CFR 485.608(d) that staff of the CAH be licensed, certified, or registered in accordance with applicable Federal, State, and local laws and regulations. The CAH and its staff must still be in compliance with applicable Federal, State and Local laws and regulations, and all patient care must be furnished in compliance with State and local laws and regulations. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan.	No	No	Yes	No	No
Medicare Physician Supervision Requirements	For services requiring direct supervision by the physician or other practitioner, that physician supervision can be provided virtually using real-time audio/video technology. Also, "direct" physician supervision is no longer required for non-surgical extended duration therapeutic services provided in hospital outpatient departments and CAHs. Instead, a physician can provide a general level of supervision for these services so that a physician is no longer required to be immediately available in the office suite.	Yes	Yes	Yes	Yes	No
Home Nursing Visits	RHCs and FQHCs can provide visiting nursing services to a beneficiary's home with fewer requirements, making it easier for homebound beneficiaries to receive care.	Yes	Yes	No	No	No
Responsibilities of Physicians in CAHs	42 C.F.R. § 485.631(b)(2). CMS is waiving the requirement for CAHs that a Doctor of Medicine or osteopathy be physically present to provide medical direction, consultation, and supervision for the services provided in the CAH at § 485.631(b)(2). CMS is retaining the regulatory language in the second part of the requirement at § 485.631(b)(2) that a physician be available "through direct radio or telephone communication, or electronic communication for consultation, assistance with medical emergencies, or patient referral." Retaining this longstanding CMS policy and related longstanding sub regulatory guidance that further described communication between CAHs and physicians will assure an appropriate level of physician direction and supervision for the services provided by the CAH.	No	No	Yes	No	No

Physician Supervision of NPs in RHCs and FQHCs	42 C.F.R. 491.8(b)(1). CMS is modifying the requirement that physicians must provide medical direction for the clinic's or center's health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners, and only to the extent permitted by state law. The physician, either in person or through telehealth and other remote communications, continues to be responsible for providing medical direction for the clinic or center's health care activities and consultation for the health care staff, and medical supervision of the remaining health care staff.	Yes	Yes	No	No	No
Training and Certification of Nurse Aides	CMS is waiving the requirements at 42 CFR 483.35(d) (with the exception of 42 CFR 483.35(d)(1)(i)), which require that a SNF and NF may not employ anyone for longer than four months unless they met the training and certification requirements under § 483.35(d). CMS is waiving these requirements to assist in potential staffing shortages seen with the COVID-19 pandemic. To ensure the health and safety of nursing home residents, CMS is not waiving 42 CFR § 483.35(d)(1)(i), which requires facilities to not use any individual working as a nurse aide for more than four months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services. We further note that we are not waiving § 483.35(c), which requires facilities to ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	No	No	No	No	Yes
Physician Delegation of Tasks in SNFs	42 C.F.R. 483.30(e)(4). CMS is waiving the requirement in § 483.30(e)(4) that prevents a physician from delegating a task when the regulations specify that the physician must perform it personally. This waiver gives physicians the ability to delegate any tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who meets the applicable definition in 42 C.F.R. 491.2 or, in the case of a clinical nurse specialist, is licensed as such by the State and is acting within the scope of practice laws as defined by State law. We are temporarily modifying this regulation to specify that any task delegated under this waiver must continue to be under the supervision of the physician. This waiver does not include the provision of § 483.30(e)(4) that prohibits a physician from delegating a task when the delegation is prohibited under State law or by the facility's own policy.	No	No	No	No	Yes

Physician Visits in SNFs	42 C.F.R. 483.30(c)(3). CMS is waiving the requirement at § 483.30(c)(3) that all required physician visits (not already exempted in § 483.30(c)(4) and (f)) must be made by the physician personally. We are modifying this provision to permit physicians to delegate any required physician visit to a nurse practitioner (NPs), physician assistant, or clinical nurse specialist who is not an employee of the facility, who is working in collaboration with a physician, and who is licensed by the State and performing within the state's scope of practice laws.	No	No	No	No	Yes
National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)	To the extent NCDs and LCDs require a specific practitioner type or physician specialty to furnish or supervise a service, during this PHE, the Chief Medical Officer or equivalent of a hospital or facility will have the authority to make those staffing decisions.[12]	No	No	Yes	Yes	No

WHA again thanks CMS for the invitation to provide input on the permanent retention of current CMS PHE-related waivers. We look forward to continuing to work with you to help our members be best positioned to care for their patients and communities.

Sincerely,

/s/

Eric Borgerding
President and Chief Executive Officer